

Program of All-Inclusive Care for the Elderly (PACE)

Request for Information Meeting Minutes

Date: February 8, 2016

Time: 10:00 am – 12:00 pm

Location: 41 Anthony Ave., Conference Room A

Facilitator: Gary Wolcott, OADS

Presenter: David Berry, OADS

Note taker: Debra Halm & Jacqui Downing

Overview: Introductions

Open floor for questions & answers

Attendees: (In person and by phone)

Gary Wolcott, OADS	Deb Halm, OADS	Jacqui Downing, OADS	Tamera Leland, Westgate	Kristie Miner, Westgate
Gretchen Zeh-Higgins, SeniorsPlus	Terry Baldwin, VOA	Elizabeth Sabourin, Fallon Health	David Przesiek, Fallon Health	Jean Mellett, EMHS
Mary Dube, GHS	Eliza Mathias, GHS	Betsy Grass, AlphaOne	Sharon Foerster, MaineHealth	Kelly Bickmore, APS Healthcare
Larry Gross, SMAA	Kristin Overton, Spectrum Generations	Larry Henry, Martins Point	David Berry, OADS	Gerry Queally, Spectrum Generations
Doreen McDaniels, OADS	Melissa Morrill, VOA	Brett Seekins, Baker Newman Noyes	Lisa McPherson, EMHS	

Introductions: Everyone introduced themselves.

Following introductions, David Berry gave a brief explanation and power point presentation of the PACE Program.

The following is a summary of questions, answers and discussion at the PACE meeting

- Are consumers given a choice
Consumers choose – they may keep other services
This is strictly a choice
There was a thank you to the Department for moving ahead with this
- Maine needs to apply to CMS
It is a one page application to state planning which starts the clock; procure providers
Back & forth process with the state & CMS
They are concerned with money
- Maine must have created a vision – but what is the vision of rural fragmented providers?
Reason for RFI not RFP; hoping to hear what you think is possible
Originally it was urban; and it was also successful rurally. There have been failures too.
Nothing is off the table; your ideas.
CMS wants more creativity and flexibility
- What have we thought about PACE
Maine is not a large state – are there enough people?

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We are having an RFI to get information from you – i.e. rural areas
What is the vision of rural fragmented providers?

- PACE to NF eligibility.
Will there be a change in this?
Risk of adjusted payment
Acuity level of NF eligibility puts strain on provider
Compared to Massachusetts there's a huge difference
Answer on RFI
Mass = NF & Residential Care in Maine
- Do all need to be in the same network
CMS adjusts and allows folks to retain Primary Care Physicians
CMS will not waive the 6 core requirements
- In Adult Day Centers – do all members have to be in PACE? Is this true?
No, they may have both but just need to be identified
- Have to adjust rates annually with Medicare rates and Maine Care rates?
We don't know, guess we would
Federal based on county – Feds determine rates
- Is there a timely knowledge of rates?
Varies
- MA explained interface w/ ACO & PACE populations – dual eligible
PACE takes full risk for member. But would not be in both ACO & PACE
PACE-provider is responsible for all care
PACE contracts with market
- Does PACE have to be their own organization
Each organization makes their own decision
Rural PACE programming – demonstration report is available and favorable by DHHS and CMS
- Is Vermont's' PACE program still operating?
No
- Is there a VA Program in ME
Does PACE allow VA's
The VA would operate under guidelines and would contract with PACE
There is no VA program in ME now
- Does PACE include Behavioral Health
Any required services need to be contracted for
Everyone bills PACE provider
It is specialized for Alzheimer/Dementia care rooms

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Contracted Services

- Are outcomes better
It is difficult because they are frail, younger, and busier
- So much is under one roof, especially urban. In Maine, to have that overhead, struggle scalability. Does it have to be under one roof?
Heard of hub & spoke models in rural area.
There have been successful models in the country
You need volume, 150-200 members
- Isn't the pool smaller? All NF eligible?
Unique areas of ME; blend together for opportunity & risk
What can work?
- Can behavioral health – telemedicine
Yes
- Can DD population work in PACE?
Yes
- How much interest for DD
Natural curiosity; nothing to go on
- Describe hub & spoke model
One in CO – primary site plus satellites w/ transportation.
CO has highest participation rate in country
- A model in NY includes pharmacy, nutrition, etc. (OT's)
Do the rules allow for sub-contractors?
How do we make it happen in areas?
- Given our population and needs-have to determine geographic area
How do we make it work for 1-2 sites? We have to look at challenges and risks in rural areas.
There are different infrastructures
Demographic information indicates 3 cities in Maine could support traditional PACE
- If it is a traditional PACE program (3 locations; what creative solutions beyond those)
How much creativity does CMS provide
We don't know until we ask
- How much interest is there in DS
We need to see the rules
Alternative sites need CMS approval

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Comment: Getting enough NF eligible in ME is a barrier. The State of Maine needs to look at NF eligibility

- If we were to do PACE, thoughts on addressing:
 - Leaving money on the table and not using more CMS money
 - Worth looking at; loosen gradually
 - Risk mitigated for PACE
- In current Adult Day Programs, how many consumers are NF level
 - Not as many
- The State of Maine needs to look at other states NF level
 - The highest eligibility in the United States is in Maine
 - If Maine's eligibility was less-could we use more waiver programs?
 - Transportation is an issue
- What about consumers who are in the community, then back to hospital, then back to community and so on.....
 - Obtain information within system
 - Identify risks and how they impact rate system
 - How does it work with CMS and risk?
 - On average, it costs 5 million to start PACE
- Do Adult Day Centers need to be licensed
 - Adult Day Centers do need to be licensed
 - Others do not change what is currently required and do not choose to be license
 - Some states choose additional level. In MA it is a PACE license
- Would insurance license be required?
 - PACE wouldn't require that in Maine
 - TBD – In Massachusetts, three party agreement (CMS, SSA, PACE)
- Would people leave NF to go to PACE
 - PACE is known for being significantly better with care transitions
 - ME does MFP now; Transition into Waivers
- Concerns on figuring out the risk. Need a sophisticated partner for risk. LTC & Acute Care side; building that in risk structure; 2 or 3 bad cases push you over the edge.
 - Not just shifting of risk, level of sophistication on financial, takes knowledge
 - Do you have to say "Yes" to all who want PACE?
 - State would vet level of understanding
- Gary Wolcott asks what we would use for criteria and process. What's right mix? Can you define?
 - Eligibility is part of the mix.
 - We have Residential Care and NF eligibility
 - Must be assessed at a home visit with a nurse or apply at the center if the team has concerns.

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The state will review any at risk; PACE does not make this decision

Voluntary joining

No application is needed

- At one point EMH had internal group requirement to work with consultant
Not required
- Any concern if sufficient expertise at State level – is it overly high risk?
Have developed risk assessment methods
Have lots of complex, high need individuals
- Scalability – Appendix C – Question: Is resolution there?
There is a tremendous amount of effort in this area.
Have a great system of care, and will work hard to support it.
Larger question of eligibility
- How do ACO's & PACE meet in the same state?
Per EMH – they are not the same, investigating this nationally
- What are reporting requirements like for PACE?
Lots of recording, more and more strict
A lot of reporting-heading towards same process as NF reporting
Separate to State on quarterly basis and yearly to National PACE organization
EMR is recommended
There is no set system for PACE
EMR goes into a comprehensive data system
Incidental events and reportable events are by Levels.
- Do you have to do MDS Assessments?
Yes
- Electronic Medical Records Required?
No, but most have them
- Level II incidents – CMS has requirements the state must follow; immediate data required
Sentinel Events – this is the old name, the name has been replaced with Level II
Incidental events and reportable events are by Levels
- HCBS – issue of cases being understaffed in Maine
In MA – contract with many agencies
Ownership of them going into homes
Staffing can be a problem
Not enough aides, but it will never be perfect
Transportation is another big need/problem

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- Can we ask for Forgiveness for lack of staff?
CMS & State are not forgiving; rely on own staff to fill in
PACE is financially challenging
Need to be Mission Driven
- Final Comment: Thank you to Gary for offering this program.